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	175298	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG BLUE HEALTHCARE, INC, DBA RIVERBEND POST ACUTE	7850 FREEMAN AVENUE KANSAS CITY, KS 66112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #149241. The 2567 was electronically sent to the facility on 01/15/2020.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/15/2020

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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to provide dignity for two of 25 sampled residents. Staff changed Resident (R) 62's wound dressing in the commons area and staff administered insulin to R109 in the commons area on second floor both with other residents present.

Findings included:

- R62's "Quarterly Minimum Data Set" (MDS), dated 11/21/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented the resident required limited staff assistance with all Activities of Daily Living (ADLs) except supervision with eating. The MDS documented the resident had a pressure reducing device for her bed, one stage III pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer), and received pressure ulcer care.

The 01/08/2020 updated "Skin Condition Care Plan," instructed staff to continue current wound treatment orders, educate resident/family/caregivers of causative factors

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and measures to prevent skin injury, and encourage good nutrition and hydration in order to promote healthier skin. The care plan instructed staff to keep the resident's skin clean and dry, use lotion on dry skin, and not apply on open areas. The care plan instructed staff to monitor and document location, size, and treatment of skin injury, and report abnormalities, failure to heal, signs and symptoms of infection, and maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces (or wounds for extended periods) to the physician. The care plan documented the resident preferred treatment to be done outside of her room.

The "Weekly Skin Evaluation," dated 11/11/19, documented the resident had an open area to her right heel.

On 01/08/2020 at 07:53 AM, observation revealed Licensed Nurse (LN) J changed the resident's right heal wound dressing while seated in the commons area, visible to other residents.

On 01/08/2020 at 07:53 AM, LN J stated he changed the resident's wound dressing in the commons area per resident request.

On 01/09/2020 at 10:02 AM, LN I stated she would change the resident's wound dressing in a private area, for instance a vacant room or the resident's room.

On 01/09/2020 at 10:36 AM, Administrative Nurse E stated staff should not change the resident's wound dressing in the commons area in front of other residents, they should take her to her room or another private area.

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The facility's undated "Resident Rights" policy documented the resident had the right to be treated with respect and dignity.

The facility failed to treat R62 with dignity when staff changed her wound dressing in the commons area with other residents present, placing her at risk for an undignified experience.

- R109's "Physician's Order Sheet" (POS), dated 12/06/2019, documented the resident had diagnoses of hyperglycemia (an excess of glucose in the bloodstream, often associated with diabetes mellitus), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Chronic Obstructive Pulmonary Disease (COPD) (lung disease that blocks airflow and makes it difficult to breath).

The "Admission Minimum Data Set" (MDS), dated 12/13/19, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed the resident required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented the resident received antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anticoagulant (medication used to prevent formation of blood clots), antibiotic (medication used to treat infections), and diuretic (medication to promote the formation and excretion of urine) medications.

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The "Activities of Daily Living Care Area Assessment" (CAA), dated 12/13/19, documented the resident recently admitted from the hospital and was alert and able to make needs known. The CAA documented the resident ambulated in her wheelchair, propelled by staff, and required extensive staff assistance with activities of daily living (ADLs).

The "Medication Care Plan," dated 12/09/19, directed staff to administer Metformin (an oral medication that helps control blood sugar levels) and to monitor and document side effects and effectiveness every shift. The care plan instructed staff to observe the resident for any changes in cognitive function, specifically changes in decision making abilities, memory recall, awareness of surroundings and others, difficulty expressing self, sleepiness and confusion. The care plan directed staff to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.

The "Nurse's Note," dated 01/08/2020 at 11:14 AM, documented the resident received 40 units of Novolog insulin (a fast-acting insulin that lowers levels of sugars in the blood, that starts to work within 15 minutes after injection, peaks in about one hour, and keeps working for two to four hours) from a licensed nurse on duty and the resident did not have an order for insulin. The Nurse Practitioner was in the facility and notified of the medication error. The nurse's notes documented the Nurse Practitioner assessed the resident and ordered the nurse to monitor the resident for signs and symptoms for hypoglycemia (lack of glucose in the

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bloodstream), and staff notified the resident of the medication error.

The "Physician's Order," dated 12/31/2019, directed staff to administer Metformin 500 milligrams (mg), one tablet by mouth once a day for diagnosis of hyperglycemia.

Review of the January 2019 "Medication Administration Record" (MAR) recorded the resident received Metformin 500 mg once a day but lacked an order for insulin.

The 01/08/2020 at 9:03 AM, observation revealed the resident sat in her wheelchair, in the Kensington Hall commons area and seven other residents sat in the area. Continued observation revealed License Nurse (LN) K approached R109 and pulled her wheelchair back and informed the resident, "[LN K] was going to give her a shot." Continued observation revealed LN K administered a shot in the residents left upper arm.

On 01/08/2020 at 09:35 AM, LN K verified she administered Novolog insulin to R109 and the resident did not have an order for insulin. LN K stated she was an agency nurse and it was her first day working on the floor. LN K verified she asked an aide who the resident was that had an order for the insulin and the aide stated she was wearing pink. LN K then administered the insulin to R109 and did not verify the resident's name with her prior to administering the insulin. LN K stated the facility told her she had to leave the building and proceeded to finish narcotic count with Administrative Nurse D.

On 01/08/2020 at 02:50 PM, Administrative Nurse

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F 550	Continued From page 6 E verified LN K administered Humalog insulin to R109, the resident did not have an order for insulin, and the nurse should not do the injections in a public area. The undated facility's "Residents Right Acknowledgement Form" documented each resident shall have the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility without interference, coercion discrimination and reprisal. The policy documented the staff would be treated with respect and dignity and the right to receive proper medical care. The facility failed to promote care for R109 in a manner to maintain and enhance dignity and respect, placing the resident at risk for an undignified experience.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		

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the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents with two reviewed for abuse. Based on observation, record review, and interview, the facility failed to report a resident to resident altercation for one of two sampled residents, Resident (R) 50.

Findings included:

- R50's "Physician Order Sheet," dated 11/18/19, documented diagnoses of dementia with behavior disturbance (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit), and cerebral infarction (an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain).

The "Quarterly Minimum Data Set" (MDS), dated

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10/05/19, documented the resident had moderately impaired cognition. The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for dressing and personal hygiene. The assessment documented the resident had verbal behavior directed toward others one to three days during the look-back period.

The "Behavior Care Area Assessment" (CAA) did not trigger.

The "Behavior Care Plan," dated 08/09/19, documented the resident had potential to demonstrate physical behaviors, like striking out, related to anger. The care plan directed staff to guide the resident away from the source of distress, engage calmly in conversation, and if the response was aggressive, calmly walk away and approach the resident later. The 10/14/19 care plan update documented the resident hit another resident on her left arm while in the dining room. The care plan lacked documentation the resident had a resident to resident altercation on 09/22/19.

The "Nurse's Note," dated 09/22/19, documented the resident hit another resident on the arm while in the dining room. The note documented the other resident did not sustain any injury and the two residents were separated.

On 01/06/2020 at 05:42 PM, observation during the supper meal revealed the resident became verbally aggressive and this surveyor overheard him state he was going to hit someone. Observation revealed the resident in his wheelchair, away from the dining table, hollering

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at his female tablemate. Observation revealed the tablemate responded to the resident and stated, "I'm not going to sit at the table with you anymore." Observation revealed staff intervened and took R50 out of the dining room to his room.

On 01/08/2020 at 11:45 AM, Licensed Nurse (LN) G stated the resident had behaviors and was easily redirectable. LN G stated the resident had more verbal behaviors than physical behaviors and staff took him to watch television to calm him down.

On 01/08/2020 at 02:48 PM, Administrative Nurse E stated she was unaware of the 09/22/19 incident, and it should have been investigated and reported. Administrative Nurse E stated Administrative Nurse D interviewed the nurse working at the time of the incident and she could not remember who R50 hit, so Administrative Nurse D contacted the CNA's working that day.

On 01/08/2020 at 03:55 PM, Certified Nurse Aide (CNA) O stated she had not seen any physical behaviors from the resident, but she was aware to contact the nurse and try to redirect the resident if he became agitated.

The facility's "Abuse Prevention and Prohibition" policy, dated 11/28/17, documented all allegations of abuse, neglect, misappropriation of resident property or exploitation would be reported outside the facility to the appropriate state or federal agencies in the applicable time frames as per this policy and applicable regulations.

The facility failed to report R50's resident to resident altercation to administrative staff and the appropriate state agency, placing the residents at

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F 609	Continued From page 10 risk for abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents with two reviewed for abuse. Based on observation, record review, and interview, the facility failed to investigate a resident to resident altercation for one of two sampled residents, Resident (R) 50. Findings included: - R50's "Physician Order Sheet," dated 11/18/19, documented diagnoses of dementia with behavior disturbance (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), cognitive	F 610		

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communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit), and cerebral infarction (an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain).

The "Quarterly Minimum Data Set" (MDS), dated 10/05/19, documented the resident had moderately impaired cognition. The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for dressing and personal hygiene. The assessment documented the resident had verbal behavior directed toward others one to three days during the look-back period.

The "Behavior Care Area Assessment" (CAA) did not trigger.

The "Behavior Care Plan," dated 08/09/19, documented the resident had potential to demonstrate physical behaviors, like striking out, related to anger. The care plan directed staff to guide the resident away from the source of distress, engage calmly in conversation, and if the response was aggressive, calmly walk away and approach the resident later. The 10/14/19 care plan update documented the resident hit another resident on her left arm while in the dining room. The care plan lacked documentation the resident had a resident to resident altercation on 09/22/19.

The "Nurse's Note," dated 09/22/19, documented the resident hit another resident on the arm while in the dining room. The note documented the

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other resident did not sustain any injury and the two residents were separated.

On 01/06/2020 at 05:42 PM, observation during the supper meal revealed the resident became verbally aggressive and this surveyor overheard him state he was going to hit someone. Observation revealed the resident in his wheelchair, away from the dining table, hollering at his female tablemate. Observation revealed the tablemate responded to the resident and stated, "I'm not going to sit at the table with you anymore." Observation revealed staff intervened and took R50 out of the dining room to his room.

On 01/08/2020 at 11:45 AM, Licensed Nurse (LN) G stated the resident had behaviors and was easily redirectable. LN G stated the resident had more verbal behaviors than physical behaviors and staff took him to watch television to calm him down.

On 01/08/2020 at 02:48 PM, Administrative Nurse E stated she was unaware of the 09/22/19 incident and it should have been investigated and reported. Administrative Nurse E stated Administrative Nurse D interviewed the nurse working at the time of the incident and she could not remember who R50 hit, so Administrative Nurse D contacted the CNA's working that day.

On 01/08/2020 at 03:55 PM, Certified Nurse Aide (CNA) O stated she had not seen any physical behaviors from the resident, but she was aware to contact the nurse and try to redirect the resident if he became agitated.

The facility's "Abuse Prevention and Prohibition" policy, dated 11/28/17, documented all allegations

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F 610	Continued From page 13 of abuse, neglect, misappropriation of resident property or exploitation would be thoroughly investigated by the administration or his/her designee. The investigation and the results of the investigation would be documented. The facility failed to investigate R50's resident to resident altercation, placing the resident's at risk for abuse.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		

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assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to update two of 25 sampled residents care plan. Resident (R) 50's care plan after a resident to resident altercation and R 100's care plan after a bolster device (used to prevent a resident from rolling out of bed) was placed in the resident's bed to prevent falls.

Findings included:

- R50's "Physician Order Sheet," dated 11/18/19, documented diagnoses of dementia with behavior disturbance (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit), and cerebral infarction (an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain).

The "Quarterly Minimum Data Set" (MDS), dated 10/05/19, documented the resident had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for dressing and personal hygiene. The assessment documented the resident had verbal behavior one to three day during the look-back period.

The "Behavior Care Area Assessment" (CAA) did

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not trigger.

The "Behavior Care Plan," dated 08/09/19, documented the resident had potential to demonstrate physical behaviors, like striking out, related to anger. The care plan directed staff to guide the resident away from the source of distress, engage calmly in conversation and if the response was aggressive, calmly walk away and approach the resident later. The 10/14/19 care plan update documented the resident had hit another resident on her left arm while in the dining room. The care plan lacked documentation the resident had a resident to resident altercation on 09/22/19.

The "Nurse's Note," dated 09/22/19, documented the resident hit another resident on the arm while in the dining room. The note documented the other resident did not sustain any injury and the two residents were separated.

On 01/06/2020 at 05:42 PM, observation revealed during the supper meal, the resident became verbally aggressive and this surveyor overheard him state he was going to hit someone. Observation revealed the resident in his wheelchair, away from the dining table, hollering at his female tablemate. The tablemate responded to the resident and stated, "I'm not going to sit at the table with you anymore." Observation revealed the staff intervened and took R50 out of the dining room to his room.

On 01/08/2020 at 11:45 AM, Administrative Nurse E stated she was unaware of the 09/22/19 resident to resident altercation and verified the altercation was not added to the resident's care plan.

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F 657	Continued From page 16 On 01/09/2020 at 01:55 PM, Administrative Nurse F stated when the interdisciplinary team met and had new interventions for a resident, the team immediately added the interventions on the care plan. Administrative Nurse F stated she had not always attended the meetings and was unaware of the 09/22/19 resident to resident altercation. The facility's "Comprehensive Person Centered Care Planning" policy, dated 08/08/17, documented the interdisciplinary team shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and timeframe's to meet a residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The team will also develop and implement a baseline care plan for each resident. The resident's comprehensive care plan will be reviewed and/or revised the interdisciplinary after each assessment. The facility failed to update R50's care plan with a resident to resident altercation, placing the resident at risk for further altercations. - R100's quarterly "Minimum Data Set" (MDS), dated 12/20/19, documented the resident had severely impaired cognition and required extensive assistance of one staff for bed mobility, and transfers. The assessment documented the resident had unsteady balance, no functional impairment and had two or more falls since admission. The "Fall Care Area Assessment" (CAA) documented the resident was impulsive and continually tried to stand up.	F 657		

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The 12/31/19 care plan documented the resident was at risk for falls and directed staff to put the residents' bed in lowest position, call light within reach, floor mats on both sides of her bed, and staff to check resident frequently. The care plan lacked documentation the resident had a bolster cushion on her bed.

On 01/08/2020 at 12:45 PM, observation revealed the resident lying in bed with a bolster cushion under the fitted sheet on the right side of the bed.

On 01/08/2020 at 02:06 PM, observation revealed the resident in bed, eyes closed with a bolster cushion under the fitted sheet on the right side of the bed.

On 01/08/2019 at 12:55 PM, Certified Nurse Aide (CNA) P stated the bolster was a barrier for the resident so she does not fall out of bed. CNA P stated the resident had falls so her bed was a low bed with the bolster and a mat placed beside the bed.

On 01/08/2020 at 02:06 PM, Administrative Nurse DD stated the bolster was used for fall prevention and kept the resident from falling out of bed.

On 01/09/2020 at 10:50 AM, Licensed Nurse (LN) L stated she was unsure how long the resident had the bolster in her bed, but it was implemented after the resident had fallen out of bed.

On 01/09/2020 at 10:55 AM, Administrative Nurse F stated the interdisciplinary team added interventions to resident care plans right after their weekly meeting. Administrative Nurse F

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F 657	Continued From page 18 stated she does not necessarily go to those meetings and was unaware the resident had a bolster in her bed. The facility's "Comprehensive Person Centered Care Planning" policy, dated August 2017, documented the interdisciplinary team shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and timeframes to meet a residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The team will also develop and implement a baseline care plan for each resident. The resident's comprehensive care plan will be reviewed and/or revised the interdisciplinary after each assessment. The facility failed to update R100's care plan after implementing a bolster cushion as a fall intervention, placing the resident at risk for use of inappropriate fall interventions.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		

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The facility had a census of 118 residents. The sample included 25 residents with one resident reviewed for activities. Based on observation, record review, and interview, the facility failed to provide activity and socialization needs for Resident (R) 78.

Findings included:

- R78's "Physician Order Sheet," dated 12/08/19, documented the resident had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dysphasia (swallowing difficulty), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), encounter for gastrostomy (surgical creation of an artificial opening into the stomach thru the abdominal wall), dementia (progressive mental disorder characterized by failing memory, confusion), and pain.

The "Quarterly Minimum Data Set" (MDS), dated 12/11/19, documented R78 had severe cognitive impairment and was dependent on one to two staff for all ADL's.

The annual MDS, dated 09/10/19, documented the resident had severe cognitive impairment. The MDS documented it was very important to the resident to listen to music and participate in religious activities, and somewhat important to do favorite activities. The MDS documented the resident dependent on one to two staff for Activities of Daily Living (ADLs), used a wheelchair for mobility, had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag), and gastrostomy tube.

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The "Cognitive Loss and Dementia Care Area Assessment" (CAA), dated 09/10/19, documented the resident had Alzheimer's disease, dementia, major depressive disorder, and severely impaired decision making skills. The CAA documented the resident alert to self when up in a wheelchair and directed staff to anticipate her needs.

The "Activity Care Plan," dated 12/23/19, documented the resident dependent on staff for activities, cognitive stimulation, and social interactions related to physical limitations, immobility and cognitive deficits. The care plan documented the resident preferred activities of music therapy group, getting her nails painted, gospel music, church devotions, and watching TV in her room. The care plan documented the resident also preferred reading spiritual materials, socials, and going outside when the weather was nice. The resident required one to one bedside visits and activities if unable to attend out of room events. The care plan documented the resident required assistance to activity functions and directed staff to provide materials for individual activities as desired such as music player, reading material, spiritual materials, magazines, and puzzles.

The "Activity Annual Evaluation," dated 09/08/19, recorded R78 did not participate in group activities mainly due to her refusal to get out of bed, received weekly one to one visits with activity staff, enjoyed getting her nails done, sensory lotion rubs, socializing with others while in her room, and watching TV in bed.

The 30 day look back documentation in the

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"Electronic Medical Record Tasks" lacked documentation for creative, entertainment, independent, mental, one to one, religious, social, and trip activities.

The resident's "Electronic Medical Record Task" recorded R78 preferred to be up in her chair after lunch. The 30 day look back documented the resident had been in her chair December 11, 12, 13, 15, 17, 21, 23, 24, 27, 28, 29, 31, 2019 and January 4, 5, and 6, 2020. Documentation revealed the R78 refused on 12/14/19. R78 had not been in her chair 10 days in the look back documentation.

The resident's "Group Activities Attendance Record" documented attendance on October 16 and 17, 2019. The resident's "One on On Activities Attendance Record" documented attendance on October 19, 20, November 1, 9, 24, December 2, 19 2019, and January 2, 2020.

On 01/08/2020 at 09:10 AM, observation revealed the resident in her room in bed, and staff entered the room to check and change the resident. The commons area on the hallway was occupied with several residents socializing with each other and staff.

On 01/08/2020 at 09:10 AM, Nurse Aide M and N, reported the resident was to get out of bed for 2 hours a day, she usually would get up after lunch time, and the next shift was who got her out of bed and into her wheelchair.

On 01/08/2020 at 02:30 PM, Activity Staff (AS) Z verified the one on one visits had not been provided on a weekly basis in October, November and December 2019 and January 2020.

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F 679	Continued From page 22 On 01/09/2020 at 10:50 AM, Licensed Nurse (LN) I reported the staff should be getting the resident up unless the resident tensed her arm to indicate she did not want to get out of bed. LN I reported she only worked one day a week at the facility and on a different hall. On 01/09/2020 at 01:35 PM, Administrative Nurse D, stated he thought R78 was up routinely in her chair in the afternoon, but could not verify that information. The facility "Activity Policy and Procedure Manual, section Delivery of Activity Services" dated July 2007, documented the activity program activities refer to any endeavor, other than routine ADL's in which a resident participates that is intended to enhance his or her sense of well-being, to promote or enhanced physical, cognitive and emotional health. These include but not limited to activities that promote self-esteem, pleasure, comfort, education, creativity, success and independence. It is the policy of this facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and physical, mental, and psychosocial well-being of the each resident. The facility failed to provide an activity program for R78, on a regular basis, placing the resident at risk for social isolation and lack of activities to enhance her physical, cognitive and emotional health.	F 679		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to act on pharmacy recommendation for one of six sampled residents, Resident (R) 98.

Findings included:

- R98's "Physician Order Sheet" (POS) dated 11/05/19, documented the resident had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, cognitive communication deficit (difficulties with communication that have an underlying cause in a cognitive deficit more than a language or speech deficit), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set" (MDS), dated 12/18/19, documented R98 had severe cognitive impairment, disorganize thinking, and required limited assistance of one staff for Activities of Daily Living (ADLs). The MDS documented the

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resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication on a regular basis, no gradual dose reduction attempt or documentation by a physician as clinically contraindicated, and medication follow up was not assessed.

The "Psychotropic Drug Use Care Area Assessment," dated 12/27/19, documented the resident was at risk for adverse reactions from psychotropic medication use, received antidepressant, antianxiety, and antipsychotic medications, and medications would be reviewed by the physician and pharmacist.

The "Psychotropic Medication Use Care Plan," dated 11/13/19, directed staff to monitor and document for side effects and effectiveness.

The "Physician Order," dated 12/02/19, directed staff to administer quetiapine (antipsychotic medication), 25 mg tablet, give one half tablet every day at bedtime for the diagnosis of agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) related to hallucinations (sensing things while awake that appear to be real, but the mind created). The previous antipsychotic medications had been discontinued.

The "Pharmacy Consult Report," dated 10/16/19, documented to ensure behavior and side effect monitoring were in place for the use of antipsychotic and a quarterly Abnormal

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F 758	Continued From page 26 Involuntary Movement Scale test (AIMS) was needed as well. The "Pharmacy Consult Report," dated 11/11/19 reviewed medications due to a fall and documented staff administered the resident multiple psychotropic medications which increased fall risk, most recent addition of quetiapine, and recommended a dose reduction. The record lack documentation of AIMS or dose reduction. On 01/09/2020 at 01:50 PM, Administrative Nurse D verified an AIMS test should have been conducted as the resident was on an antipsychotic and if the pharmacist recommended it, it should have been completed. The facility "Care and Treatment Psychotropic Drug Use" policy, dated August 2017, documented the attending physician will review the resident's treatment plan, in collaboration with the consultant pharmacist, to re-evaluate the use of psychotropic medication, and consider whether or not medication can be reduced or discontinued upon admission or soon after admission, and monitor for adverse consequences and effectiveness of the medications are in place. The facility failed to ensure R98's medication regimen was free of unnecessary medications, placing resident at risk for adverse side effects.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		

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§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure one of the six sampled residents, Resident (R)109, remained free from a significant medication error when staff administered when staff administered insulin to the wrong resident (R109).

Findings included:

- R109's "Physician's Order Sheet" (POS), dated 12/06/2019, documented the resident had diagnoses of hyperglycemia (an excess of glucose in the bloodstream, often associated with diabetes mellitus), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Chronic Obstructive Pulmonary Disease (COPD) (lung disease that blocks airflow and makes it difficult to breath).

The "Admission Minimum Data Set" (MDS), dated 12/13/19, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed the resident required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented the resident received antidepressant, anticoagulant, antibiotic, and diuretic medications.

The "Activities of Daily Living Care Area

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Assessment" (CAA), dated 12/13/19, documented the resident recently admitted from the hospital and was alert and able to make needs known. The CAA documented the resident ambulated in her wheelchair, propelled by staff, and required extensive staff assistance with activities of daily living (ADLs).

The "Medication Care Plan," dated 12/09/19, directed staff to administer Metformin (an oral medication that helped control blood sugar levels) and to monitor and document side effects and effectiveness every shift. The care plan instructed staff to observe the resident for any changes in cognitive function, specifically changes in decision making abilities, memory recall, awareness of surroundings and others, difficulty expressing self, sleepiness, and confusion. The care plan directed staff to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.

The "Nurse's Note," dated 01/08/2020 at 11:14 AM, documented the resident received 40 units of Novolog insulin (a fast-acting insulin that lowers levels of sugars in the blood, that starts to work within 15 minutes after injection, peaks in about one hour, and keeps working for two to four hours) from a licensed nurse on duty and the resident did not have an order for insulin. The Nurse Practitioner was in the facility and notified of the medication error. The nurse's note documented the Nurse Practitioner assessed the resident and ordered the nurse to monitor the resident for signs and symptoms for hypoglycemia (lack of glucose in the bloodstream), and staff notified the resident of the medication error.

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The "Nurse's Note," dated 01/08/2020 at 11:15 AM, documented the resident received Humalog, not Novolog as previously documented. The nurse administered glucagon and monitored the resident's blood glucose every thirty minutes.

The "Nurse's Note," dated 01/08/2020 at 03:07 PM, documented the resident complained of chest pain and requested to go to the hospital, and the nurse obtained the resident's vitals, all within normal limits for the resident. The note's documented the resident had an order for nitroglycerin (a medication used to relax and dilate the blood vessels, improving blood flow), she refused to take it, and the resident transported to the hospital.

The "Nurse's Note," dated 01/08/2020 at 07:59 PM, documented the resident admitted to the hospital for influenza.

The "Physician's Order," dated 12/31/2019, directed staff to administer Metformin 500 milligrams (mg), one tablet by mouth once a day for diagnosis of hyperglycemia.

Review of the January 2019 "Medication Administration Record" (MAR) recorded the resident received Metformin 500 mg once a day, but lacked an order for insulin.

Review of the resident's "Vitals - Blood Sugar" values for 01/08/2020 recorded the following values:
03:01 PM, 74.0 (milligrams per deciliter mg/dl)
03:25 PM, 74.0 mg/dl

Review of the "Facility Reported Incident" dated

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01/08/2020 recorded the following resident's blood sugar values:
9:25 AM, 119 mg/dl
9:55 AM, 100 mg/dl
10:30 AM, 46 mg/dl (gave glucose gel pack)
10:50 AM, 48 mg/dl

The 01/08/2020 at 9:03 AM, observation revealed the resident sat in her wheelchair, in the Kensington Hall commons area and seven other residents sat in the area. Continued observation revealed License Nurse (LN) K approached R109 and pulled her wheelchair back and informed the resident, "[LN K] was going to give her a shot." Continued observation revealed LN K administered a shot in the residents left upper arm.

On 01/08/2020 at 09:35 AM, LN K verified she administered Novolog insulin to R109 and the resident did not have an order for insulin. LN K stated she was an agency nurse and it was her first day working on the floor. LN K verified she asked an aide who the resident was that had an order for the insulin and the aide stated she was wearing pink. LN K then administered the insulin to R109 and did not verify the resident's name with her or ask her what her name was, then proceeded to administer the insulin to her. LN K stated the facility told her she had to leave the building.

On 1/08/2020 at 2:50 PM, Administrative Nurse E verified LN K administered Humalog insulin to R109 and the resident did not have an order for insulin. Administrative Nurse E verified the facility provided training on the "Six Rights of Giving Resident's Medication" after the incident and reviewed the insulin error. Administrative Nurse E

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F 760	Continued From page 31 verified she contacted the three agencies they contract with to hire nurses and explained the facility had Point Click Care program (electronic documentation of the resident's medical record) with a picture of each resident in the program. The facility's "Insulin, Injection Administration" policy, dated May 2007, documented the facility would administer insulin to control blood sugar levels for the residents with insulin dependent diabetes mellitus. The policy documented the nurse would bring equipment to the bedside and screen the resident, then identify the resident by means of identification bracelet and explain the procedure. The facility failed to ensure staff administered R109 the correct medication, placing the resident at risk for complications from low blood sugar.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to ensure stock medications were not expired in two of four medication carts.

Findings included:

- On 01/06/2020 at 12:10 PM, observation during initial tour revealed the following expired medications in the Kensington South medication cart:

One bottle of zinc sulfate (dietary supplement used to treat zinc deficiency), 220 milligrams (mg), 100 tablets, expired December 2019.

One bottle of calcium citrate (dietary supplement used to treat calcium deficiency), 250 mg, 100 caplets, expired December 2019.

On 01/06/2020 at 12:30 PM, observation revealed the following expired medications in the Kensington North medication cart:

One bottle of bisacodyl (laxative), 5 mg, 100 tablets, expired March 2019.

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F 761	Continued From page 33 One bottle of zinc sulfate, 220 mg, 100 tablets, expired December 2019. One bottle of Thera - Tabs multivitamin, 100 caplets, expired December 2019 On 01/06/2020 at 12:15 PM, Licensed Nurse (LN) G verified the above expired stock medication on the Kensington South medication cart. On 01/06/2020 at 12:40 PM, LN H verified the above expired stock medication on the Kensington North medication cart. On 1/09/2020 at 4:10 PM, Administrative Nurse D stated the nurses were to discard expired medications. Administrative Nurse D stated the nurses checked the medication carts for expired medications once a week. The facility's "Medication Access and Storage" policy, dated May 2007, documented outdated, contaminated, or deteriorated medications and those on containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy. The facility failed to ensure stock medications were not expired, placing the residents at risk for use of an ineffective medication.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions for meals prepared in the facility's kitchen.

Findings included:

- On 01/08/2020 at 03:30 PM, during kitchen observation, the oven and stove areas that were positioned back to back with other ovens and prep area had an accumulation of brown material on the tubing and cordage.

On 01/08/2020 at 04:30 PM, during meal preparation, observation revealed Dietary Staff (DS) CC checked temperature of the meal in preparation to serve from the production line steam table. DS CC placed the thermometer into food items on the steam table, and between each

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F 812	Continued From page 35 food item, he walked to the sink, rinsed the thermometer with water, then dried the thermometer with a paper towel. DS CC repeated this process with the meatloaf, pureed meatloaf, green beans, pureed green beans, mashed potatoes, and gravy. On 01/08/2020 at 05:00 PM, DS BB verified the area behind and between the equipment had accumulation of brown material on tubing and cords, and this area was not specified on the cleaning schedules. DS BB also verified DS CC should have used an alcohol pad to clean the thermometer between food items, and the alcohol pads were stored on shelf near the steam table. The facility "Cleaning Instruction" policy, dated 2016, instructed at least once a month, large appliances will be moved to clean behind and underneath them. The facility "Monitoring Food Temperatures for Meal Service" policy, dated 2016, documented thermometers are washed, rinsed, sanitized between uses. An alcohol swab may be used to sanitize between uses while taking temperatures of the same meal, or if contamination of the thermometer occurs. The facility failed to thoroughly clean the oven and stove areas in the kitchen and properly clean the thermometer while checking food temperatures for the meals served to 3 of the 4 dining rooms in the facility, placing the residents at risk of consuming contaminated food.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 36 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of infections for one of four residents reviewed for pressure ulcers, when staff changed Resident (R) 62's infected heel dressing in the commons area.

Findings included:

- R62's "Quarterly Minimum Data Set" (MDS),

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dated 11/21/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented the resident required limited staff assistance with all Activities of Daily Living (ADLs) except supervision with eating. The MDS documented the resident had a pressure reducing device for her bed, one Stage III pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer), and received pressure ulcer care.

The 01/08/2020 updated "Skin Condition Care Plan," instructed staff to continue current wound treatment orders, educate resident/family/caregivers of causative factors and measures to prevent skin injury, and encourage good nutrition and hydration in order to promote healthier skin. The care plan instructed staff to keep the resident's skin clean and dry, use lotion on dry skin, and not apply on open areas. The care plan instructed staff to monitor and document location, size, and treatment of skin injury, and report abnormalities, failure to heal, signs and symptoms of infection, and maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces (or wounds for extended periods) to the physician. The care plan documented the resident preferred treatment to be done outside of her room.

The "Weekly Skin Evaluation," dated 01/06/19, documented the resident had an open area to her right heel.

Review of the "Laboratory Results" from 01/06/2020-01/08/2020 revealed no documentation staff obtained a wound culture (a

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diagnostic laboratory test in which microorganisms (bacteria, virus, or fungus) from an infected wound are grown in the laboratory on media and identified) of the resident's Stage III right heel pressure ulcer.

Review of the "Physician Orders" from 01/06/2020-01/08/2020 revealed no documentation of a physician order for a wound culture of the resident's right heel pressure ulcer.

On 01/08/2020 at 07:53 AM, observation revealed Licensed Nurse (LN) J applied gloves, removed the resident's heel dressing, and placed the soiled dressing in the common area trash can. Observation revealed LN J cleansed the resident's right heel open wound with wound wash on a four by four gauze pad, removed and discarded gloves in the same trash can, applied new gloves, and applied skin prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) around the wound. Observation revealed LN J then placed an optifoam (nonadhesive foam dressing) over the wound in view of other residents.

On 01/08/2020 at 07:53 AM, LN J stated he changed the resident's wound dressing in the commons area per the resident's request.

On 01/09/2020 at 10:02 AM, LN I stated she would change the resident's wound dressing in a private area.

On 01/09/2020 at 10:36 AM, Administrative Nurse E stated she was unaware of the type of infection the resident had in her right heel pressure ulcer wound and verified staff had not conducted a

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wound culture. Administrative Nurse E stated staff should not change the resident's wound dressing in the commons area, they should take her to her room or another private area.

On 01/09/2020 at 11:56 AM, Consulting Staff(CS) GG stated she was in the facility the previous week and noted the wound had increased drainage and redness. CS GG stated on 01/06/2020 staff reported the wound was worsening so she prescribed an antibiotic. CS GG verified she had not ordered a wound culture to see what type of infection was in the resident's wound. CS GG stated staff should never change an open wound, even if it is not draining, in the commons area around other residents. Protocol is for staff to change a dressing in the resident's room, place the dressing in a trash bag in the resident's room, and when done with dressing change, tie up the bag and remove to the dirty utility room.

The facility's "Infection Control Program" policy, dated November 2017, documented it was the policy of the facility to address detection, prevention and control of infections among patients and personnel.

The facility failed to provide a sanitary environment to help prevent the development and transmission of infections when staff changed R62's infected wound dressing in the commons area with other residents present and disposed of the dressing in the commons area trash can, placing the residents at risk for infection.